Mental Health & Substance Abuse Workgroup Recommendations

On March 9, 2004, LTCIP Planning Committee members reached consensus on the recommendations listed below, which will serve as guiding principles in preparing for and implementing LTCIP. A broad array of mental health & substance abuse providers, consumers and consumer advocates were invited to participate in the workgroup. Stakeholders dedicated over 200 hours to the recommendation development process. Please be sure to read the rationale that follows for a more detailed explanation of the recommendations.

We support the integration of health and social services and funding for persons with mental illness and/or substance abuse issues. We recommend that the Planning Committee pursue an implementation plan that follows these guiding principles:

1. ***Mental health and substance abuse services should be included in LTCIP, beginning phase-in with the 65 year old and older population.***

2. ***Persons under 65 with severe and persistent mental illness and/or substance abuse issues are phased in to LTCIP at a later date when the collection of stakeholder concerns has been addressed satisfactorily.***

3. ***Depression, mental health and substance abuse screening should be included in LTCIP risk screening.***

4. ***Research on successful behavioral health models should be continued for the 65+ to insure a policy of parity between general medical care and behavioral health services at initial implementation. This will also be done for the under 65 when phase-in for this group is implemented.***

5. ***LTCIP should protect existing funding principles for physical, mental health and substance abuse services, as a step toward delivering effective, integrated services.***

6. ***State contracting language should allow psychiatrists to serve some primary care functions for persons with a primary diagnosis of mental illness.***

Rationale for Mental Health & Substance Abuse Workgroup recommendations:

1. The 65+ population is seen as a reasonable starting point for phase I implementation. Mental health/substance abuse stakeholders agreed that it would be best to begin LTCIP implementation with a small, manageable group in order to gain experience in and build network capacity for providing population-based, integrated MH & SA services. This thinking is consistent with input from other community stakeholders within the LTCIP planning & development process of the last five years.

2. Stakeholders recommended phasing-in the younger (64 and under) mentally ill at a later date to allow time to (a) gain expertise in providing MH & SA services, (b) monitor & evaluate phase I to identify problems and make necessary system improvements; and (c) effectively address the unique needs, systematic requirements and other concerns regarding the under 65 group.

3. While depression, mental health and substance abuse screening is becoming standard practice in many physician offices, stakeholders felt it was necessary to emphasize the importance of including this type of risk screening in LTCIP. Dr. McCahill noted that this practice is supported by a similar recommendation made by the U.S. Preventive Services Task Force in May 2002, which states that primary care physicians nationwide should be screening all adult patients on a regular basis for depression.

4. On-going research review and analysis of successful behavioral health models to identify best practices, track outcomes, and evaluate program performance is important for continued LTCIP stakeholder education and informed decision-making. Number four originally read, "Research on successful behavioral health models is continued for the 65+ to insure a policy of parity for behavioral health services at initial implementation and for the under 65 when phase-in for this group is implemented*."* "*General medical care*" was added to clarify that parity refers to fairness or impartiality between behavioral health care (i.e., mental health and substance abuse) and general medical care (i.e., physical) when it comes to access, options, service delivery, reimbursement and all other aspects of care. Grammatical changes (replacing "*is*" with "*should be*" and separating the recommendation into two sentences) were made for the purposes of fluency and simplification.

5. Recommendation five originally read, "LTCIP funding is consistent with protecting existing funding principles for physical, mental health and substance abuse services*." "Should"* replaced *"is"* and the phrase, *"as a step toward delivering effective, integrated services,"* was added for clarity. The intent of this recommendation is not to maintain the status quo (e.g., inadequate funding for MH and/or SA), but to act as a starting point or middle ground for engaging providers in exploring & discussing strategies for evolving reimbursement methodologies that support adequate and appropriate funding for physical, mental health and substance abuse services.

6. Recommendation six originally read, "State contracting language allows psychiatrists to be designated as the primary care physician for persons with a primary diagnosis of mental illness." Throughout the LTCIP planning and development process, stakeholders (consumers/consumer advocates, caregivers and providers) have stated that many younger persons w/ mental illness/conditions and/or substance use issues have a more established, on-going relationship with a psychiatrist rather than a primary care physician (PCP). Thus, the patient feels more comfortable with and is more likely to seek help or care from their psychiatrist rather than a PCP. In such situations, the psychiatrist often becomes the primary provider in coordinating care, as they are more aware of and knowledgeable about the holistic needs of the patient.

   While it may be appropriate for psychiatrists to serve some primary care functions to help facilitate continuity of care, stakeholders also expressed concern that general medical care remain a function of the primary care physician. It was discussed that the PCP needs to remain an active part of the care management team and be involved in care plan development to assure that all needs are met and services are appropriate. Care plan development should involve on-going communication between/among the PCP, psychiatrist and other members of the care management team (consumer, caregiver, case manager, etc).